

MINNESOTA AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

I hereby authorize _____, DDS at _____
(Print Prior Dentist/Dental Office) (Print Prior Office Address)

_____ to release the information in the dental record of _____
(Print Prior Office Phone Number) (Print Patient's Name)

_____ to Dr. Jeffrey P. Fish D.D.S., 107 W. Main Street, Crosby, MN 56441, Ph: 218-546-6031,
(Print Patient's Date of Birth)

Fax: 218-546—8159, Email: info@jpfishdds.com.

The purpose of this release of health information is: _____

All information regarding my treatment in your office (*check appropriate*)

- between dates _____ to _____, or
(Start Date) (End Date)
- related to all treatment

may be released including, but not limited to mental health records, drug or alcohol abuse records, which are protected by state or federal law, or HIV test results and related health care issues; if any, except as specifically provided below.

Optional: I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed by MN Statute 144.335, Subd. 5. Since the charges change annually, call the Department of health at 800-657-3793 or at 612-282-6314 for the most accurate amount.

This authorization is effective now and will remain in effect until (date no longer than 1 year). I understand that I may revoke this authorization before the year is over. I understand that I may receive a copy of this authorization.

Patient's Name

Date

Signature* (Person Responsible for Patient)

Relationship, if not signed by the patient

(Parent/Guardian of Minor, Guardian/Conservator of an Incompetent Patient, or Beneficiary or Personal Representative of Deceased Patient)

Print Name* (Person Responsible for Patient)